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Clinical Quality Measures (CQM) – Part of the Future of Healthcare PQRI and PQRS – Part of the Past which Created the Future

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Part of the future of healthcare where healthcare provider will be paid for the quality of the work they do and not just the quantity of work, will be Clinical Quality Measures, or CQMs. These are tools that help measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) within our health care system. These measures use data associated with providers' ability to deliver high-quality care or relate to long term goals for quality health care. CQMs measure many aspects of patient care including:

- health outcomes
- clinical processes
- patient safety
- efficient use of health care resources
- care coordination
- patient engagements
- population and public health
- adherence to clinical guidelines

Measuring and reporting CQMs helps to ensure that our health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care.

PQRS: Making Transparency in Healthcare Work for You

The first step in the process of CMS measuring quality was the **Physician Quality Reporting Initiative** (PQRI) authorized by The 2006 Tax Relief and Health Care Act which required the establishment of PQRI, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period).

SETMA began participating in the PQRI program in January 2008, reporting data in 2009 and receiving our first payment in 2010. The 2009 PQRI Measures Specifications Manual for

Claims and Registry Release Notes is a 442-page document which explains this program. PQRI required that a practice report on at least three individual measures or one "Measures Group" (a comprehensive group of measures which apply to a single condition such as diabetes, preventive care, etc.) in order to be recognized by CMS. For 2009, SETMA reported on two measurement groups - Preventive Medicine and Diabetes - which have a total of 28 individual measures. For 2010, SETMA expanded its PQRI report to include almost sixty quality measures.

In 2009, SETMA inaugurated a unique program of public reporting by provider name on over 200 quality metrics. For the past eight years, those reports are posted on SETMA's website at www.jamesholllymd.com. In the beginning, SETMA reported on the following quality metrics:

- 34 **NCQA HEDIS** measures;
- 14 **NCQA Diabetes Recognition Metrics**;
- 35 **NQF**-endorsed measures;
- 27 **PQRS** measures required for Patient-Centered Medical Home,
- 9 **PCPI** measures related to the physician role in hypertension management;
- 43 measures of the **Bridges to Excellence** program for Asthma, Chronic Stable Angina, Congestive Heart Failure, COPD, Diabetes and Hypertension;
- 10 **PCPI** related to Diabetes;
- 6 **PCPI** for Stages 4 and 5 of Chronic Kidney Disease;
- 5 **PCPI** for Chronic Stable Angina;
- 7 **PCPI** for Congestive Heart Failure;
- 20 **PCPI** Transition of Care measures.

Since then SETMA has also tracked quality metrics sets required for the Medicare Advantage STARS program and for Accountable Care Organizations. CQM is now a part of the Meaningful Use program, in which SETMA fulfilled Meaning Use I and II. The third step, which originally was to be called Meaningful Use III has been renamed just "Meaningful Use." It is now impossible to report Meaningful Use data without including CQM data.

In the beginning PQRI was voluntary. In 2010, The Affordable Care Act made quality reporting mandatory and established penalties for not reporting. Thus in 2011, the name was changed to **Physician Quality Reporting System (PQRS)** which according to CMS is, "... gives...practices the opportunity to assess the quality of care they provide to their patients, helping ensure that patients get the right care at the right time."

A weakness of PQRS was that it could also be used to encourage cookie-cutter treatment, a potential consequence that every healthcare facility must overcome. If the system is poorly used, it can make previously careful doctors put data extraction and expected protocols over patient well being. This doesn't happen because the system itself is defunct, but rather because PQRS is not used in a patient-centric way.

To avoid this weakness, SETMA developed a Quality Metrics Philosophy which included these assumptions:

1. Quality metrics are not an end in themselves. Optimal health at optimal cost is the goal of quality care. Quality metrics are simply “sign posts along the way.” They give directions to health. And the metrics are like a healthcare “Global Positioning Service”: it tells you where you want to be; where you are, and how to get from here to there.
2. The auditing of quality metrics gives providers a coordinate of where they are in the care of a patient or a population of patients.
3. Statistical analytics are like coordinates along the way to the destination of optimal health at optimal cost. Ultimately, the goal will be measured by the well-being of patients, but the guide posts to that destination are given by the analysis of patient and patient-population data.
4. There are different classes of quality metrics. No metric alone provides a granular portrait of the quality of care a patient receives, but all together, multiple sets of metrics can give an indication of whether the patient’s care is going in the right direction or not. Some of the categories of quality metrics are: access, outcome, patient experience, process, structure and costs of care.
5. The collection of quality metrics should be incidental to the care patients are receiving and should not be the object of care. Consequently, the design of the data aggregation in the care process must be as non-intrusive as possible. Notwithstanding, the very act of collecting, aggregating and reporting data will tend to create a Hawthorne effect.
6. The power of quality metrics, like the benefit of the GPS, is enhanced if the healthcare provider and the patient are able to know the coordinates while care is being received.
7. Public reporting of quality metrics by provider name must not be a novelty in healthcare but must be the standard. Even with the acknowledgment of the Hawthorne effect, the improvement in healthcare outcomes achieved with public reporting is real.
8. Quality metrics are not static. New research and improved models of care will require updating and modifying metrics.

Patient Input

Patients have incredible value in the quality-reporting field. Their input can be used to guide reporting and the use of public records can offer enough transparency to drive future action. CMS’ purpose is to set a national quality strategy, not to highlight poor quality care. It’s thus critical that actionable goals be set and strategies for improvement be created. Negative data shouldn’t be feared. Instead, it should be viewed as an opportunity to move forward more efficiently in the future. The level of information patients and caregivers offer can prevent progress, so their participation must be actively encouraged.

Internal and External Data Usage

Analytics are only useful if they’re adapted to the correct audiences. While public records have the power to improve transparency in healthcare, raw data are useless. Performance information must be churned into something meaningful for every audience, from healthcare providers to patients. CMS wants caregivers and patients to play a more active role in their care; a goal that can only be achieved in a transparent healthcare environment. Through Patient-Centered Medical Home and the Public Reporting by Provider Name of quality metrics results, SETMA has determined to participate in this movement.